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Health insurance and access to health care services in developing countries

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ABSTRACT

There is growing awareness of the fact that ill-health perpetuates poverty. In order to prevent the negative downward spiral of poverty and illness, developing countries in recent years are increasingly implementing various models of health insurance to increase access to health care for poor households. While there is consistent evidence that health insurance schemes have caused an increase in access to health generally, the debate regarding the most appropriate health insurance scheme that suits the poor continues unabated. Drawing on relevant literature this paper adopts a framework for assessing access to health care services to explore four dimensions of access, including: geographic accessibility, availability, affordability, acceptability of services. The paper argues that irrespective of the model of health insurance being implemented these dimensions of access govern the poor and the poorest household decisions about enrolling in a health insurance scheme and utilizing health care services. Policy makers and planners need to pay attention to these important dimensions when making decisions regarding health insurance and health care services utilization to ensure that the peculiar needs of the poor are taken on board.

Key words: access, developing countries, health insurance models, universal health coverage,

particular have effective access to health care (Agyepong and Adjei, 2008, Agyepong and Nagai, 2011, Agyepong et al., 2011, Jehu-Appiah et al., 2011, Jehu-Appiah et al., 2012, Kanchebe Derbile and van der Geest, 2013, Apoya and Marriott, 2011, Frempong et al., 2009, Mensah et al., 2010, Akazili et al., 2012, Goudge et al., 2012, Dixon et al., 2013). Other alternatives financing arrangements such as the Cost Recovery System have been criticized for causing drastic reduction in access and utilization of health care services (Mensah et al., 2010, Gilson et al., 2000, Kanchebe Derbile and van der Geest, 2013).

The government of Ghana, for instance, passed a National Health Insurance Act 650 in 2003 mandating the establishment of district-wide Mutual Health Organizations (MHO) to replace out-of-pocket payment and increase access to health care (Dixon et al., 2013, Mensah et al., 2010, Kanchebe Derbile and van der Geest, 2013, Jehu-Appiah et al., 2011). Since then the National Health Insurance Scheme (NHIS) coverage has expanded significantly and currently there are a total of 145 District Mutual Health Insurance Schemes (DMHIS) and 33% of the population enrolled (NHIA, 2012). Empirical evidence shows, however, that the NHIS may not be pro-poor despite the fact that premiums are relatively low and exemptions are in place to protect the core poor (Ceri and Anna, 2013, Apoya and Marriott, 2011, Durairaj et al., 2010). Apoya (2011), observe that although average outpatient visits per member per year were between 1.4 and 1.5 in 2009 against a national average of 0.81, coverage of the NHIS was exaggerated and could be as low as 18%. From this figure the rich constituted 64% while the poor constituted only 29%. According to Ceri and Anna (2013) the majority of the poor are excluded as these schemes prioritize advantaged groups in the formal sector of the economy.

Recent literatures have also examined the factors that determine enrolment and access to care. Whereas some have focused on demographic and socio-economic characteristics (Buor, 2005, De Allegri et al., 2009, Nketiah-Amponsah, 2009, Asante and Aikins, 2007), others have examined the dimension of user preferences and perceptions and conclude that a good understand-

INTRODUCTION

Many developing countries including Ghana, South Africa, Tanzania, Kenya, Thailand etc. have been implementing various forms health insurance schemes in recent times with the objective of ensuring that the poor in

TABLE 1.2, SUMMARY OF THE SCOPE, PROS AND CONS OF THE DIFFERENT FORMS HEALTH FINANCING MECHANISM

MECHANISM	SCOPE	STRENGTHS	WEAKNESSES
Tax-based health insurance	<ul style="list-style-type: none"> Equity depending on design of tax system Coverage and outreach Sustainability Potential for efficiency 	<ul style="list-style-type: none"> Pools risks for whole population. Potential for administrative efficiency and cost control. Redistributes between high and low risk and high- and low- income groups in the covered population 	<ul style="list-style-type: none"> Risk of unstable funding and often underfunding due to competing public expenditure Inefficient due to lack of incentives and effective public supervision
Social health insurance	<ul style="list-style-type: none"> Coverage of formal economy Increased fiscal space Public support Financial soundness Allows to target government funds to the poor 	<ul style="list-style-type: none"> Generates stable revenues Often strong support from population Provides access to a broad package of services Involvement of social partners Redistributes between high and low risk and high- and low- income groups in the covered population 	<ul style="list-style-type: none"> Poor are excluded unless subsidized Payroll contributions can reduce competitiveness and lead to higher unemployment Complex to manage governance and accountability can be problematic Can lead to cost escalation unless effective contracting mechanisms are in place
Micro-insurance and community-based insurance schemes	<ul style="list-style-type: none"> Resource collection from the non-salaried Allows to target public funds to poor Increases fiscal space Potential to reach out to those who can pay or are subsidised 	<ul style="list-style-type: none"> Can reach out to workers in the informal economy Can reach the close-to-poor segments of the population Strong social control limits abuse and fraud and contributes to confidence in the scheme 	<ul style="list-style-type: none"> Poor may be excluded unless subsidized Maybe financially vulnerable if not supported by national subsidies Coverage usually only extended to a small percentage of the population Strong incentive to adverse selection Maybe associated with lack of professionalism in governance and administration
Private health insurance	<ul style="list-style-type: none"> Increase fiscal space Allows to target government funds to the poor 	<ul style="list-style-type: none"> Preferable to out-of-pocket expenditure Increases financial protection and access to health services for those able to pay Encourages better quality and cost efficiency of health care 	<ul style="list-style-type: none"> High administrative costs Ineffective in reducing cost pressures on public health financing systems Inequitable without subsidized premiums or regulated insurance content and price Requires administrative and financial infrastructure and capacity

Table 1.2, Adapted from (ILO, 2008a, Oxfam, 2008)

ing of users' preferences and perceptions and incorporating these into the design of health insurance schemes may increase enrolment rates, thus ensuring the poor have improved access to care (Arhinful, 2003, De Allegri et al., 2009). Jehu-Appiah et al (2011) and Carin (2003) provide useful conceptual models for analysing enrolment outcomes yet because enrolment does not necessarily guarantee access to health care, as Jost (2008) observe in the case of the United States where many poor people enrolled in a scheme and did not have access to medical care. Besides, these models have failed to address the idea of integrating traditional medicine into the health systems in developing countries to make health care acceptable and inclusive for users who either by habit or circumstances do not access allopathic medicine.

Given this background, the purpose of this paper is twofold: first of all, it critically reviews the various models of health insurance in order to ascertain the

relative capacity of each scheme to improve effective access to care to the poor within a development context. In the conclusion the paper introduced a conceptual framework for assessing access to health services. This innovative framework helps to identify the dimensions and determinants of access to health care services to the poor and poorest household. An understanding of these factors would draw the attention of researchers, planners and policy makers to the needs of the poor such that future decision making regarding health insurance and health care services utilization would prioritize and take on board these peculiar needs.

METHODOLOGY

The paper is produced from desk research with data obtained mostly from published material including library books, journal articles, serials, published reports, policy papers, NHIA annual reports and health sector

reports, all of which are appropriately cited and referenced using endnote X7 Harvard (brad) style.

MODELS OF HEALTH INSURANCE

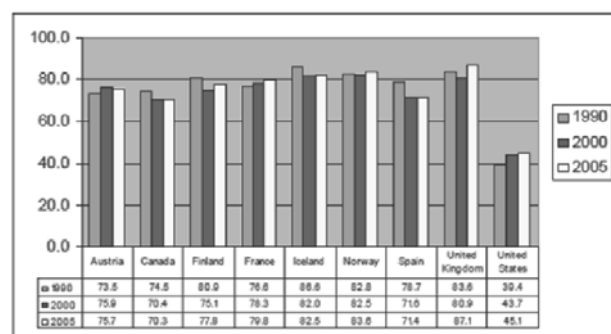
Most countries around the world are committed to developing an effective health insurance system for the purpose of achieving universal coverage. Yet, there is an on-going debate on the relative advantages of different forms of health insurance (Asgary et al., 2004, Oxfam, 2008, ILO, 2008a). The purposes of health financing are to mobilise resources for the health system, to set the right financial incentives for providers, and to ensure that all individuals have access to effective health care. The United Kingdom, for example has developed a tax-based national health system that covers every resident (Light, 2003, Savedoff, 2004b, Wagstaff and Bank, 2009). Social health insurance on other hand relies on employees contributing a percentage of their salaries to a health insurance fund that is used to refund affiliates' health expenditures (Normand and Weber, 2009a, Carrin and James, 2005, Wagstaff and Bank, 2009, Wagstaff, 2010, Witter and Garshong, 2009, Oxfam, 2008). Private health insurance is said to mainly serve the affluent segments of a population, and it offers health plans covering a specified list of health conditions in exchange for a renewable premium (Sekhri and Savedoff, 2005, Pauly et al., 2006, Huff Rousselle and Akuamoah Boateng, 1998, ILO, 2008a, Oxfam, 2008). Community-based health schemes on the other hand are common in low and middle-income countries often targeted to benefit the poor and in many countries it is used to mobilize supplementary revenues to support fragmented health systems or pluralistic financing systems (Criel et al., 1999, Atim, 1998, Oxfam, 2008, ILO, 2008a, Dave, 1991, Ekman, 2004, Jütting, 2004, Preker et al., 2002, Preker et al., 2007, Hsiao, 2004, Chankova et al., 2008, Arhin-Tenkorang, 2004b).

Table 1.2 is summary of the scope, pros and cons of these health financing mechanisms used in countries across the globe. Drawing on the framework by (Preker and Carrin, 2004) this part of the review examines the extent to which the different forms of health insurance schemes can mobilise resources, provide financial protection to the insured against catastrophic health expenditures and increase access to quality health care to the poor in particular.

PRIVATE HEALTH INSURANCE (PHI)

Private health insurance (PHI) is becoming more prevalent in both developed and developing countries, yet it plays a limited role increasing access to health care in developing countries. Out of the 154 developing countries, only 11 fund more than 10 percent of their health care through PHI (Ceri and Anna, 2013, Oxfam, 2008). Some commentators (Oxfam, 2008, Ceri and Anna, 2013), have observed that while PHI can increase financial protection and access to quality health services to the well-off, without subsidies however, the poor cannot afford to pay PHI premiums. PHI does not support risk sharing, it rather employs the cream-skimming strategy – a practice where insurance policies are designed to target people with lower-than-average risks and exclude those with high risks. This practice deprives vulnerable groups including women, the elderly and people living with HIV access to care. South Africa and the United States are the only countries that rely heavily on PHI (accounting for 42% and 32% of total health spending respectively). Neither South Africa or the USA is close to achieving UHC and they are amongst the most inequitable health systems in the world (Ceri and Anna, 2013) Figure 1 confirms that USA is the only OECD country that has not achieved UHC.

FIGURE 1: PUBLIC EXPENDITURE ON HEALTH AS A PERCENTAGE OF TOTAL HEALTH EXPENDITURE FOR SELECTED OECD COUNTRIES, 1990, 2000, 2005



Source: OECD (2006)

Reference to Latin America, where PHI was introduced in the 1980s, private schemes typically cover the percentile of the population with the highest income. Low-income groups are left with existing social insurance schemes, which offer fewer benefits, or have no health insurance at all. Inequalities of this nature have been reported in Argentina, Chile, Colombia, Brazil, and Peru

(Oxfam, 2008), and Georgia (Ceri and Anna, 2013).

Given this lack of equity and efficiency, PHI systems alone do not seem to have a solution to the health problems facing developing countries. Whereas PHI models have run alongside complement tax-based or SHI complementarily in developed countries, on its own, however, it is not an appropriate financing option to achieve UHC in developing countries whose population are mostly poor, sick and cannot afford risk-related premiums.

COMMUNITY-BASED HEALTH INSURANCE (CBHI)

Community-based health insurance is the most common form of health care financing in many developing countries (Normand and Weber, 2009a, Ceri and Anna, 2013). It comes as a result of governments' inability to reach the informal sector and rural populations, requiring communities to mobilize and secure financial protection against the cost of illness for groups of individuals and households not covered by existing insurance schemes. A variety of community-based health financing arrangements have emerged over the past decade, including micro insurance, community health funds, mutual health organizations, rural health insurance, revolving drugs funds, and community involvement in user-fee management (Preker et al., 2002). Regardless of the arrangement, a common feature is that they facilitate explicit or implicit involvement of community members in the design and implementation process that limits abuse and fraud and contributes to trust and confidence in the scheme (Normand and Weber, 2009a, Atim, 1998, Arhin-Tenkorang, 2004c, ILO, 2008a).

Research has given evidence that community financing arrangements provide financial protection by reducing out of pocket (OOP) spending and by increasing access to health services; improved access to drugs, primary care, including more advanced hospital care (Dave, 1991, Preker et al., 2002). However, the very low and shrinking population coverage rates cast doubts over the validity of this finding (Ekman, 2004). Ceri and Anna (2013) observe that it is possible for CBHI to provide some financial risk protection in the absence of a national health insurance scheme. However, their potential to progress toward universal coverage is limited. A number of reasons account for this assertion: enrolment is limited and so far CBHI schemes cover only two

million of the estimated 900 million people in Africa (Ceri and Anna, 2013). There is also evidence to suggest that CBHI still exclude the very poor groups with little effect on access to care for these target populations (Hsiao, 2001, Atim, 1998, Jütting, 2000, Arhin-Tenkorang, 2004a, ILO, 2008a, Ekman, 2004, Ceri and Anna, 2013, Oxfam, 2008). Exclusion of the very poor from schemes adds credence to (Pradhan and Prescott, 2002) findings that community financing in Indonesia did not eliminate the need for government subsidies for health care and broader coverage for catastrophic health care expenditures.

The second reason is that CBHI do not generate sufficient revenue and are not financially viable in the long term. Most often, low premiums are charged and yet the cost of collecting premiums can be high. As such, these schemes are unable to generate the required amount of revenue to provide subsidy for the poor (Ceri and Anna, 2013, Oxfam, 2008, Ekman, 2004). Thirdly, the CBHI do not have large risk pools. New evidence suggests that out of 258 schemes reviewed; only 2% had more than 100,000 members, more than half of them had less than 500 members (De Allegri et al., 2009). With limited revenue at their disposal CBHI schemes tend to cover a limited number of services, severely limiting the financial protection offered. Ekman (2004) thus suggests that there is insufficient evidence that CBHI can be a viable option for sustainable financing of primary health care in low-income countries primarily because these schemes have been found to be incapable of mobilizing sufficient amounts of resources. Having said that, Arhin-Tenkorang (2004b), has given evidence of relatively few CBHI in Ghana, Tanzania, Burundi, Guinea Bissau and DR Congo, that have operated sustainably for several years, thus giving the impression that CBHI can be a feasible alternative in certain contexts and situations. Such schemes, he argues, have been successful on two counts; they based their contribution calculations on willingness to pay (WTP) data or managed to arrive at affordable or near affordable premiums for their target populations. Other schemes have been able to mobilize sufficient external funding and provided acceptable health care benefit package for members.

Given these contexts, it has been argued that CBHI can lead to the achievement of universal coverage and high cross-subsidization between low income households through the future linking of fragmented schemes for the

informal sector to each other and to schemes for the formal sector in a bid toward establishing a national health insurance scheme (Arhin-Tenkorang, 2004b, Normand and Weber, 2009a)

SOCIAL HEALTH INSURANCE (SHI)

SHI schemes are often financed through mandatory earnings related contributions levied on formal sector workers. Though people with higher contributions are not entitled to more health care, non-contributors may have different entitlements to contributors. In some cases too people contributing to different schemes may have different entitlements from one another (Normand and Weber, 2009a, Wagstaff, 2007, Wagstaff, 2010, Wagstaff and Bank, 2009). Unlike private health insurance schemes, social health insurance contributions are usually based on ability to pay and are not risk-related, and access to services is based on need. In a typical SHI scheme, entitlements to services are usually universal and not differentiated, and contribution rates are set at a level intended to ensure that these entitlements are affordable to members (Normand and Weber, 2009b).

Through SHI, high-income countries such as Germany, Luxembourg, Belgium, and France have achieved formal UHC. In developing countries however, SHI schemes are found to exclude populations in the informal sector and the larger the informal sector the larger the coverage gap. In the absence of reliable income records premiums are charged at a flat rate; mostly unaffordable to the poor. And, even though exemptions exist for vulnerable groups like the elderly, children, indigent, the disabled and pregnant women, errors of exclusion and inclusion still occur, culminating in low enrolment. Tanzania has been implementing SHI schemes for the past 10 years yet coverage is only 17 percent. Kenya's National Health Fund has been running for nearly 50 years and only 18 percent of the population is covered (Ceri and Anna, 2013). Even developed countries such as Germany took as long as 127 years to achieve UHC via SHI and people in developing countries would not be happy wait that long to achieve universal coverage.

One key question however is how much revenue can developing countries raise using SHI, given that a large proportion of the population is outside the formal sector? In these countries, SHI revenue can at best offer supplementary revenues for pluralistic financing of health system (Wagstaff, 2010, Wagstaff and Bank, 2009). In

countries such as Thailand, Egypt, Syria, Yemen, considerable progress has been made towards universal coverage by adopting pluralistic financing of health system, that is, supplementing tax revenues with SHI and CHBI contributions (ILO, 2008a). Similarly, Ghana's Health Insurance Scheme relies heavily on tax funding for 70–75% of its revenue supplemented with SHI informal sector contributions, grants and subsidies (Witter and Garshong, 2009, Jehu-Appiah et al., 2012, NHIA, 2012).

The ILO observes that the success of SHI schemes is dependent on the generation of stable revenues, strong backing of the beneficiary population, provision of a broad package of services, participation of the social partners and redistribution between risk and income groups (ILO, 2008b). It is argued in this connection that the pioneers of social health insurance such as Germany, Luxembourg, Belgium, and France have achieved formal universal coverage as a result of their progress in general social and economic development: the labour markets, financial markets, legislation, institutional infrastructure, and capacity to collect taxes, (ILO, 2008a). In the absence of these necessary conditions, as often the case in developing countries, SHI schemes can be difficult to administer and governance and accountability can be challenging (Carrin, 2002). Experiences of SHI schemes in Vietnam and China in the early 1990s showed that the absence of health services infrastructure, human resources, including other necessary components such as drugs and laboratory examination made little sense to start SHI scheme (Carrin, 2002). In addition, (Wagstaff, 2010) argues that SHI does not necessarily deliver good quality care at a low cost, partly due to poor regulation of SHI purchasers. He observes that the cost of collecting contributions is often substantial, even in the formal sector where non-enrolment and evasion are common.

Therefore, the challenges low income countries are facing in extending coverage to the often sizeable informal sector suggest that reliance on a single financing mechanism to achieve universal coverage will be long and frustrating. However, worldwide experience and evidence show that most national health financing systems are based on multiple options that cover disjointed or overlapping subgroups of the population, while others remain uncovered. The health financing experiences of Egypt, Yemen, Syria, but in particular, Thailand's model, is a good example developing countries can replicate, (Barrientos, 2010, ILO, 2008a).

TAX-BASED SYSTEMS (TBS)

Tax-based systems, sometimes referred to as national health services pay for health services out of general government revenue such as direct or indirect tax from various levels, including national and local tax (Normand and Weber, 2009b, ILO, 2008b, Ceri and Anna, 2013). These taxes are often used for various forms of health insurance funding. Aside from financing national health services, vouchers or conditional cash benefits, taxes are used as subsidies for mixed health insurance programmes such as national health insurances, whereby government revenues are used to subsidize the poor. In addition, taxes may be used as subsidies for social health insurance, community-based mutual health and private health insurance schemes. Subsidies from government revenue might cover costs for the poor, deficits, specific services, and start-up or investment costs (ILO, 2008b).

Tax-Based Systems originated in two separate ways (Agyepong et al., 2011, Savedoff and WHO, 2004). In the first set of countries, this financing system developed on a foundation provided by the earlier development of social or private health insurance. For instance, Britain passed its National Insurance Act in 1911 that was financed through payroll contributions, and didn't adopt a tax-base health system until after the Second World War. The spread of tax-based health financing across Western European countries followed this pattern. In the second set of countries, the Tax-Based System evolved from health services ran directly by colonial administrations. This pattern is common in developing countries that were colonized or influenced in terms of development policy by Britain. Among this set of countries include Malaysia, Singapore, Hong Kong, and many countries in Africa and the Caribbean.

Irrespective of the starting point, Tax-Based Systems share common pluses and shortcomings. The mandatory system of payment makes Tax-Based Systems benefit from scale economies in administration, purchasing power and especially risk management, that leads to national risk pooling for the whole population and redistribute between high and low health risks, and high- and low-income groups (Wagstaff, 2010, Preker et al., 2002, Savedoff and WHO, 2004). These benefits are drawn from the collective and political nature of raising and allocating tax revenues in a modern nation-state. Nonetheless, this same political-economic feature serves as a weakness in terms of inefficiencies that emerge from

serving multiple objectives, political pressures to serve privileged groups, the ineffective management in public services, and the difficulties related to weak accountability and instability (World Bank, 2004). Besides, this financing mechanism is not able to meet the demand by privileged groups for more sophisticated health care or expensive amenities and forces everyone into taking the same standard of health care. This is one of the key reasons why tax-based national health insurance is not favoured in America. Attempts by many low income countries to implement pro-rich health spending has led to leakage of government funds to the rich at the expense of the rest of the population (Wagstaff, 2010).

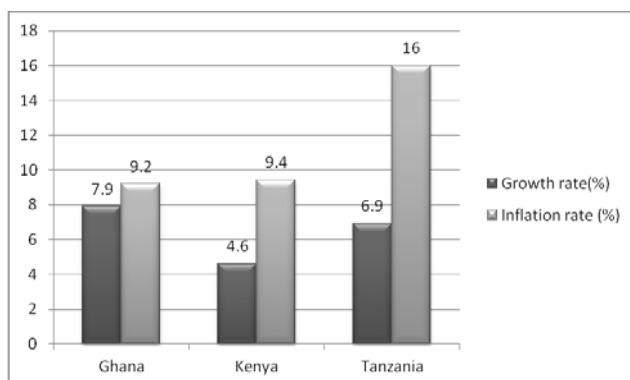
An effective model, as some would argue, is the model used in countries like Britain, Brazil, Ireland, Malaysia, Sri Lanka and Sweden, where the providers get paid by government that monitors the sophistication of services and where it is delivered. This strategy compels the rich who desire expensive care to seek it through the private sector which operates as a limited safety valve (Savedoff and WHO, 2004). However, owing to the narrow tax base and a limited organizational capacity to enforce tax compliance or prevent extensive tax evasion health services financing via general taxation remains a big challenge for developing countries. The success of tax-based health-care financing is largely contingent upon the quality of governance, the size of the tax base, and the government's human and institutional capacity to collect taxes and supervise the system. Britain, Brazil, Ireland, Malaysia, Sri Lanka and Sweden have been successful because of their strong economic and institutional capacity to effectively mobilize resources and supervise the delivery of health services (Wagstaff, 2010, ILO, 2008b, Savedoff, 2004a, Carrin, 2002, Ceri and Anna, 2013). Given the analogy above, the quest for universal coverage in developing countries remains elusive, yet the ILO argues that use of pluralistic health financing mechanisms (home-grown health financing systems) is the best way to improve access to the poor. This means using multiple financing mechanism including SHI and other contributions to supplement tax revenues.

HOME-GROWN HEALTH FINANCING MECHANISMS

Drawing on the success story of Brazil, Thailand, Malaysia and Sri Lanka, developing countries that have strong political will can afford some basic social protec-

tion in health. A combination of contribution-based financing and tax-financed subsidies will help to cover population groups of epidemiological necessities (ILO, 2008a, Ceri and Anna, 2013). By employing multiple financing mechanisms the burden of health care expenditure is spread among a broader tax base while at the same time allowing room for cross subsidy by enrolling contributors and non-contributors in the same pool. This is the strategy Thailand employed and achieved near-universal coverage (97.8%), (ILO, 2008a, Hanvoravongchai and Hsiao, 2007). The Thai health coverage has three main schemes: the Fringe Benefit Scheme, the Social Security Health Insurance (SSO) and the Universal health Care Scheme (UC), (WHO, 2005). The fringe benefit scheme covers enterprise employees, pensioners and dependents. The social security health insurance on the other hand extends coverage to private sector formal economy workers, while the universal health scheme offers full access to all Thai citizens who are not affiliated to either of the two schemes. Owing to the successful implementation of these schemes, as of 2006, Thailand's overall health insurance coverage stood at a remarkable 97.8 per cent of the population, (ILO, 2008a).

FIGURE 2: GROWTH AND INFLATION RATES COMPARED FOR GHANA, KENYA AND TANZANIA - 2012



Source: World Bank Countries Data (2014)

While the Thai case remains exemplary there are two questions that developing countries intending to follow the same pathway must address: first, the fiscal space, the ability to raise additional funds in order to cover the majority of the population. With reference to the countries implementing home-grown schemes, apart from Sri Lanka, Thailand, Brazil and Malaysia are upper middle income countries thus their capacity to mobilize addi-

tional resources to fund UHC. On the contrary however, Ghana is a lower middle income country; Kenya and Tanzania are low income countries with a GDP of 40.71 billion, 40.70 billion and 28.24 billion respectively. With low GDP, and inflation rates exceeding growth rates (figure 2) these countries would struggle to raise enough funds for home-grown health financing for UHC.

The second point is whether developing countries like Ghana, Kenya and Tanzania, have the capacity to coordinate disjointed or overlapping schemes? Empirical evidence shows that poor coordination results in gaps in coverage and access to health services and the poor are the hardest hit (ILO, 2008a, Normand and Weber, 2009a). Thus, coordinating disjointed and overlapping schemes require a good health care and ICT infrastructure and the availability of administrative and professional workforce to implement the programme. In addition, a strong political will is needed to secure the much needed financial and legal backing for the programme's sustainability, (Peters et al., 2008, Dethier, 2009, Barrientos, 2010, ILO, 2008a).

It is clear from this review that regardless of the model of health insurance adopted, developing countries would still face a huge challenge extending health coverage to the poor. Some evaluation studies (Peters et al., 2008, Jehu-Appiah et al., 2011, Whitehead et al., 2001, Wagstaff, 2002), suggest that the peculiar needs of the poor have for a long time been ignored in the design of so-called pro poor health insurance schemes and as such the barriers that hinder poor households' access to care still remain. To explore these barriers of access to health care an integrated conceptual framework for assessing access to health care is required to inform the design of these schemes.

CONCLUSION

This paper set out to review relevant conceptual literature for analysing health insurance as a tool for increasing access to health care services for the poor. The first section reviewed the debates on the relative advantages of the various forms of health insurance mechanisms being carried out in the developed and the developing countries. This review paper has demonstrated that whereas it was possible for developed countries to achieve UHC relying largely on either taxes or payroll contributions, the challenges developing countries face in extending coverage to the majority of

their populations working in the informal sector, suggest that a reliance on single health financing mechanism to achieve universal coverage will be long and frustrating.

Although PHI provides insurance coverage and access to health care services to the well-off, high cost of premiums imply that only a small group of people can enrol. As a consequence, the role of PHI toward UHC has been negligible and has in some cases increased inequity of access to health care services. With reference to CBHI, there is limited evidence to suggest that this model of health can be a viable option in the quest for UHC in developing countries. Although Preker et al (2002) claim that this model makes a positive contribution toward extending health coverage at low-income levels, thus reducing OOP spending and increasing access to health care, there is also prove that such schemes cover a small group of the population and sometimes exclude the very poor because of insufficient funds to subsidise or exempt them from paying premiums (Ekman, 2004). This review also revealed that although SHI led to the achievement of UHC in many developed countries, yet replicating same models in developing has not been smooth so far. Services are restricted to formal sector workers and their dependents from the outset, and even when open to all the contribution for the informal sector is generally a flat rate; not based on ability to pay and as such those who cannot afford the premiums are excluded. This claim is confirmed by a recent study which observed that 'there is no strong evidence to support widespread scaling up of SHI as a means of increasing financial protection from health shocks or of improving access to health care,' (Acharya et al., 2012:8). Finally, Tax-based health financing is not also a viable option on the grounds that developing countries do not have the much needed broad tax based, yet at the same they lack the organizational capacity to enforce tax compliance or even prevent extensive tax evasion. It would be recalled that the success of tax-based health-care financing is largely contingent upon the quality of governance, the size of the tax base, and the government's human and institutional capacity to collect taxes and supervise the system. Thus, Britain, Brazil, Ireland, Malaysia, Sri Lanka and Sweden have been successful because of their strong economic and institutional capacity to effectively mobilize resources and supervise the delivery of health services (Wagstaff, 2010, ILO, 2008b, Savedoff, 2004a, Carrin, 2002, Ceri and

Anna, 2013).

Given the observations above, the quest for universal health coverage in developing countries looks elusive. Yet, the ILO, WHO and OXFAM argue that a number of developing countries such as Thailand, Malaysia, Sri Lanka and Brazil have made good progress toward UHC using home-grown health financing systems which are equitable and universal (Ceri and Anna, 2013). While there is ample evidence to back this claim there is also ample evidence to suggest that using home-grown health financing models might still prove to be a challenge for developing countries, especially countries in Sub Saharan countries. The commonest challenge is the fiscal space, the ability to raise additional funds in order to cover the majority of the population. The other challenge is the lack of capacity to coordinate disjointed or overlapping schemes? Experience and evidence show that poor coordination results in gaps in coverage and access to health services and the poor are the hardest hit. A promising feature though, is that the NHIS in Ghana is home grown and covers 33% of the total population since its establishment in 2004 (NHIA, 2012). The worry however, from the perspective of the poor is that 64% of the well-off are registered compared with only 29% of the poorest (Apoya and Marriott, 2011).

Whereas it is apparent that addressing the fiscal challenges to achieved UHC will take a considerable period of time, it is possible for developing countries to take immediate steps to address the problem of inequity in access to health care services of which the poor are at a disadvantage. An innovative approach in this direction is the framework for assessing access to health services. Originally developed by Aday and Andersen (1974), in their quest to find an integrated model for assessing access to medical care in America, this framework was later adopted by Peters et al (2008) to explain the reasons behind the disparities in access to health care services. The framework incorporates four dimensions of access, including, geographic accessibility, availability, financial accessibility, acceptability of services to identify important areas to look for barriers of access to health care, any of which may be the most important factor in a given time and place. This framework posits that many of the factors affecting access to health care are to do with the way policies are designed and implemented locally, and are subject to change over time. The worry is that the poor are consistently at a disadvantage in many of the

dimensions of access to health care services. It thus requires that special attention be given to the unique challenges faced by poor groups this innovative framework in developing and identifying health insurance models that show most promise in paying attention to improving health care services to the poor and vulnerable populations. Within this framework planners and policy makers would be able to make informed decisions about health insurance models that would address challenges such as distance to health facilities, the affordability of premiums, the availability and quality of services offered to the poor. For developing countries intending to implement home-grown health insurance schemes, the needs of the poor must be assessed and addressed in the design and implementation process in order to make health care services accessible to the poor. For developing countries that are already implementing various health insurance models, there is still a great opportunity to learn useful lessons from experience and remodel their schemes to address the unique challenges faced by the poor. Achieving universal coverage will be long and frustrating for most developing countries however, making health care services more accessible and acceptable to the poor only requires designing and implementing the right policies at the right time.

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